STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AFTER HEARING

Adjud. Case #:

Vulnerable Persons Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

By: Jonathan G. Johnsen. Esq.
Creighton, Johnsen & Giroux
560 Ellicott Square Building
295 Main Street
Buffalo, New York 14203

The Findings of Fact and Conclusions of Law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied as to "Allegation 1", but is granted as to "Allegation 2." The Subject has been shown by a preponderance of the evidence to have committed neglect alleged in "Allegation 1" of the substantiation letter.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is

denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: March 29, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #s:

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224-3604
On:

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

By: Jonathan G. Johnsen. Esq.
Creighton, Johnsen & Giroux
560 Ellicott Square Building
295 Main Street
Buffalo, New York 14203

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and 14 NYCRR 700.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated , , of neglect by the Subjects of the Service Recipient.

2. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

> It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

3. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

4. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

Allegation 2

It was alleged that between and , at the , located at , while acting as a custodian, you committed neglect when you failed to ensure that a service recipient received a treatment and dietary supplement in a timely fashion.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

5. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

6. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

7. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

8. After investigation of role in the report, the Justice Center concluded that:

Allegation 1

> It was alleged that on various dates between and , at the , located at , while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

9. An Administrative Review was conducted and as a result, the substantiated reports were retained.

10. The facility, , is a group home located at , and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. Each of the Subjects was employed in the capacity of Direct Support Assistant (DSA). The Subjects were custodians as that term is so defined in Social Services Law § 488(2).

11. At the time of the alleged neglect, the Service Recipient had been a resident of the facility for approximately two years. The Service Recipient was a person who used a wheelchair, but could go from a seated to a standing position for transfers. The Service Recipient was also a person with an unspecified psychiatric disorder, diabetes and significant neuropathy. The Service Recipient also experienced fecal and urinary incontinence and utilized an adult diaper. (Hearing testimony of OPWDD RN , and Justice Center Exhibit 26) The Service Recipient had good verbal skills and was communicative. (Hearing testimony of OPWDD RN) Because the Service Recipient was diabetic and

nearly always required a wheelchair, he historically suffered from pressure wounds on his buttocks. Sometime in , the Service Recipient recovered from pressure wounds that had healed after a course of treatment. (Hearing testimony of OPWDD RN)

12. The Service Recipient attended a day program Monday through Friday and departed from his residence to his day program by 7:30 a.m. each morning. (Hearing testimony of OPWDD Investigator) On [1], staff at the day program discovered and documented two pressure wounds on the Service Recipient's buttocks. (Hearing testimony of OPWDD RN)

13. On , a facility direct care staff member documented one wound on the left buttock as being 2 cm by 1 cm and one wound on the right buttock as being 1.5 cm by .5 cm, with no swelling noted. (Justice Center Exhibit 26)

14. The Service Recipient had a medical appointment on , in which a medical practitioner evaluated the pressure wounds and noted the wounds to be two "pea sized" wounds 1 cm by .5 cm on the buttocks, with no evidence of infection. The medical practitioner prescribed Allevyn adhesive dressing (the dressing), 3 inch by 3 inch size to be applied once daily. (Justice Center Exhibits 12 and 13) Subject accompanied the Service Recipient to this medical appointment. (Hearing testimony of Subject) The purpose of the dressing was not only to protect the wound from debris and foreign organisms but also to promote healing by maintaining a specified temperature range and keeping the wound moist. Once the dressing was removed and reapplied, it could take as many as four hours for the

[1] The record is not clear. The discovery of the pressure wound was made on either the (Justice Center Exhibit 40, p. 4 and Hearing testimony of OPWDD RN)

optimal temperature and moisture level of the wounds to be obtained again. (Hearing testimony of OPWDD RN)

15. The medical practitioner did not dictate a specific time of the day for administration of the dressing. medication policy dictates that when the prescriber does not specify a time for administration of medicine, the staff must rely upon the Medication Procedure Manual: Medication Administration Times Agreement (Times Agreement), to determine when a Service Recipient is to receive medication. The Times Agreement for the Service Recipient specified that he should receive medicine between 6:30 a.m. and 7:30 a.m. (Justice Center Exhibit 22) All of the Subjects were medication administration certified (MAT Certified). (Hearing Testimony of OPWDD Investigator)

16. The Registered Nurse (RN) initially responsible for the care of the Service Recipient (Nurse-A) created a pressure wound Plan of Nursing Services (PONS) on . All of the Subjects signed and acknowledged the PONS. (Justice Center Exhibit 23) The PONS required that facility direct care staff document the wound condition in the Service Recipient's residential notes after each daily dressing change. Specifically, the PONS stated, in relevant part, that staff was instructed to note in the residential notes the "…appearance of wound bed, presence of odor, color, amount of drainage and surrounding tissue appearance after each daily dressing change…" (Justice Center Exhibit 23) The PONS also stated, in bold letters, "all staff at time of initial training must read and sign the back of this (PONS) form." (Justice Center Exhibit 23) All of the Subjects who participated in this hearing had signed the "PONS Q&A Signature Sheet." (Justice Center Exhibit 23)

17. Following the medical appointment of , one of the Subjects correctly transcribed the prescription for the dressing into the Service Recipient's Medication Administration Record (MAR). (Justice Center Exhibit 27) Another one of the Subjects verified the transcribed prescription. The process of transcription required that both the transcriber and the verifying staff compare the prescription, the medication instruction label generated by the pharmacy, and the Times Agreement. (Hearing testimony of OPWDD RN) After review of those documents and labels, the transcribing staff correctly noted in the Service Recipient's MAR that the dressing was to be changed, once daily between 6:30 a.m. and 7:30 a.m. Nurse-A and all provider agency nurses were required to review the MAR once per week. Direct care staff members relied upon the MAR for guidance regarding medication and treatment administration. Ultimately, pursuant to provider agency practice and protocol, a service recipient's MAR dictated when, and what type of medication or treatment, that service recipient received from direct care staff. (Hearing testimony of OPWDD Investigator)

18. On , the pharmacy delivered the dressing to the facility. (Hearing testimony of OPWDD RN and Hearing testimony of Subject)

19. By email dated , the agency dietician recommended that the supplement Arginaid (the supplement) be given to the Service Recipient to enhance his capacity for wound healing. The email was sent to Nurse-A, and the house supervisor. (Justice Center Exhibit 58) Although Subject was designated as the Medical Liaison for the residence, she did not receive this email and did not become aware of the dietician's recommendation for administration of the supplement until after a medical care practitioner ordered/prescribed the supplement. (Hearing testimony of Subject and

Hearing testimony of OPWDD RN) The house supervisor did not read the email until , at which time she faxed the request for the supplement to the Service Recipient's medical practitioner. The house supervisor did not thereafter follow up with the staff member who had accompanied the Service Recipient to his next medical appointment on , to ensure that a prescription for the supplement was obtained. The supplement finally arrived at the facility on . (Justice Center Exhibit 41, p. 31)

20. On , the Service Recipient's pressure wounds were evaluated by a medical practitioner. During the evaluation, the medical practitioner began to suspect infection and therefore prescribed an antibiotic. The medical practitioner also obtained a wound tissue sample to culture in order to identify the bacteria and, thereafter, recommended an antibiotic that would be effective against said bacteria. (Hearing testimony of OPWDD RN and Justice Center Exhibit 14) The medical practitioner took no measurements of the pressure wounds and characterized the wounds as Stage 1[2] (right buttock) and Stage 2 (left buttock). The medical practitioner continued with the use of the dressing once daily for both wounds, but also prescribed Duoderm Hydroactive Sterile Gel (the gel), to be applied once daily, along with the dressing, to the wound on the left buttock. The medical practitioner did not indicate a specific time of the day for administration of either therapy and did not note in any written prescription that the gel was to be administered along with the dressing. (Justice Center Exhibits 14 and 15) However, one of the direct care staff[3] members who accompanied the Service Recipient to the appointment on , documented the specific directive in the

[2] Pressure wounds are commonly staged as follows: an area of the skin reddens in Stage 1, after which a wound penetrates the first and second layers of skin in Stages 2 and 3, respectively, until the wound reaches the muscle and bone in Stage 4. (Hearing testimony of OPWDD RN)

[3] The identity of the staff documenting the directive in the residential notes was never clarified in the record.

Health Care Data Sheet (Justice Center Exhibit 17) and in the residential notes, that the gel was to be administered along with the dressing. (Justice Center Exhibit 26, seventh page)

21. The gel was delivered by the pharmacy, and first became available for direct care staff use, on . (Hearing testimony of OPWDD RN and Hearing testimony of Subject)

22. After the medical appointment of , a facility direct care staff member transcribed the prescription for the gel into the Service Recipient's MAR. (Justice Center Exhibit 27) The process of transcription required that both the transcribing employee and the verifying employee compare the prescription, the medication instruction label generated by the pharmacy, and the Times Agreement. (Hearing testimony of OPWDD and Hearing testimony of OPWDD Investigator) After review of those documents and labels, the transcribing employee incorrectly noted in the Service Recipient's MAR that the gel was to be administered to the Service Recipient once daily at 8:00 p.m., instead of 7:30 a.m. as called for in the Times Agreement. The verifying direct care staff member, Subject , did not discover the error. (Hearing testimony of OPWDD RN)

23. Sometime after , likely on or about , the house supervisor told staff that the dressing should "come off of" the Service Recipient at night. (Justice Center Exhibit 40) The house supervisor may have consulted with Nurse-A before advancing this directive. (Justice Center Exhibit 41 and Hearing testimony of Subject)

24. The Service Recipient was next evaluated by an outside medical practitioner on . Results of the culture were available and revealed that the

antibiotic prescribed on was ineffective against the specific bacteria identified by the culture. Based upon the information provided by the culture, the medical practitioner prescribed a different antibiotic, one known to be effective against the strain of bacteria found in the Service Recipient's pressure wounds. The medical practitioner described the Service Recipient's pressure wound on the left buttock as a Stage 2 pressure ulcer, but made no mention of the wound on the right buttock. (Justice Center Exhibit 16 and Hearing testimony of OPWDD RN)

Subject

25. was employed at the facility for approximately five years at the time of the report. (Hearing testimony of Subject)

26. On and , Subject worked the 7:00 a.m. to 3:00 p.m. shift. She signed the MAR on each of those dates indicating that she had changed the dressing, which was scheduled to occur between 6:30 a.m. and 7:30 a.m. (Hearing testimony of Subject)

27. Subject was assigned the duty of medication administration on and . (Justice Center Exhibit 28) While not formally assigned medication administration duties on , Subject did change the Service Recipient's wound dressing on that date. (Justice Center Exhibit 27 and Justice Center Exhibit 36, p. 8, line 16 and Hearing testimony of Subject)

28. Subject failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date when she changed the dressing on the Service Recipient's wounds. (Justice Center Exhibit 26)

29. On , Subject signed the MAR indicating that she had changed the dressing that covered the Service Recipient's wounds, but in fact, she did not apply the dressing and she likely relied upon the representation of another employee that the dressing had been changed. (Justice Center Exhibit 36, p. 8, lines 19-23 and Hearing testimony of Subject)

Subject

30. Subject worked the overnight shift (11:00 p.m. to 7:00 a.m.) on the following dates: . (Justice Center Exhibit 28 and Hearing testimony of Subject) On , she worked the 7:00 a.m. to 11:00 a.m. shift. (Justice Center Exhibit 37, p. 5, lines 19-22 and Hearing testimony of Subject)

31. Subject placed her initials in the MAR indicating that she changed the dressing on , and .[4] (Hearing testimony of Subject and Justice Center Exhibit 27) However, on each of those dates, rather than changing the Service Recipient's dressing herself, she instead relied upon her supervisor's representation that the dressing had already been changed. (Hearing testimony of Subject and Justice Center Exhibit 27)

32. Subject failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date when she changed the dressing, or on any date which she represented in the MAR that she had changed the dressing. (Justice Center Exhibit 26)

[4] The record is unclear as to which shift this Subject worked on ; however, at the hearing this Subject testified that, on this date, although she documented in the MAR that she had administered the dressing, she had not in fact done so.

Subject

33. Subject worked the 7:00 a.m. to 3:00 p.m. shift on , and , on which days she was assigned the task of medication administration. (Justice Center Exhibits 27 and 28) On , Subject signed the MAR indicating that she had changed the dressing, despite not having actually done so. (Justice Center Exhibit 40, pp. 8-9)

34. Subject failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date when she changed the dressing or on any date when she represented in the MAR that she had changed the dressing. (Justice Center Exhibit 26)

Subject

35. On , Subject worked the 3:00 p.m. to 11:00 p.m. shift. (Justice Center Exhibits 27 and 38) On that date, during Subject shift, she was instructed by the house supervisor to remove the dressing. At about 7:30 p.m., she removed the dressing for the evening and documented the condition of the wound in the residential notes. Subject did not reapply the dressing or cover the wound during the overnight. (Justice Center Exhibit 38, p. 11; Justice Center Exhibit 26 and Hearing testimony of Subject)

Subject

36. Subject worked the 7:00 a.m. to 3:00 p.m. shift on and . On those dates, Subject did not change the Service Recipient's dressing because he observed his supervisor applying a new dressing during morning hygiene with the Service Recipient. (Hearing testimony of Subject) However, Subject

noted in the MAR that he had changed the dressing on both dates. (Justice Center Exhibit 27)

37. Subject failed to document the condition of wounds in the residential notes, as directed by the PONS, on any date when he changed the dressing or on any date when he represented in the MAR that he had changed the dressing. (Justice Center Exhibit 26)

Subject

38. On unknown dates between and , Subject worked with multiple staff to change the Service Recipient's dressing. On one of those occasions, he changed the dressing but another staff member signed the MAR indicating that he, rather than Subject , had changed the dressing. (Hearing testimony of Subject)

39. Subject failed to document the condition of wound in the residential notes at any time and on any date when he changed the dressing or on any date when he represented in the MAR that he had changed the dressing. (Justice Center Exhibit 26)

40. At some point in time between and , Subject observed the house supervisor having a discussion with Nurse-A. Shortly thereafter, the house supervisor advised him that Nurse-A directed that staff should remove the dressing to "air it out" at night. Because of the house supervisor's directive, on an unknown date, sometime between , and , Subject removed the dressing from the Service Recipient's pressure wound and left the wound to air out overnight. (Hearing testimony of Subject)

Subject

41. On , Subject worked the 3:00 p.m. to 11:00 p.m. shift. (Hearing testimony of Subject) She was assigned the task of medication administration but because of the house supervisor's directive to allow the Service Recipient's wounds to air out, she failed to reapply the Service Recipient's dressing after she administered the gel at 8:00 p.m.

42. On , Subject , though obligated to do so, failed to properly verify the correct transcription of the medical practitioner's orders of , into the MAR.

Time period of to

43. The supplement arrived at the facility on . (Justice Center Exhibit 41, p. 31)

44. On , OPWDD notified the Justice Center of these issues, (Justice Center Exhibit 10), and OPWDD RN took over responsibility for the wound care of the Service Recipient.[5] As of , direct care staff at the facility was no longer involved in the wound care of the Service Recipient. (Hearing testimony of OPWDD RN)

45. The Service Recipient was next evaluated by an outside medical practitioner on , when he was seen by a wound care practitioner. OPWDD RN accompanied the Service Recipient to the medical appointment. The medical practitioner continued the most recent antibiotic prescription as written by the medical

[5] Although OPWDD RN testified that she took over the wound care of the Service Recipient on , the MAR indicates that the staff administered the dressing and the gel to the Service Recipient on , but not on any date thereafter. Therefore, it appears that OPWDD RN took over care of the Service Recipient's wound on .

practitioner two days prior, and additionally prescribed a chemical debridement agent, a medication intended to dissolve necrotic tissue in the wound. The wound could not be staged when viewed by the wound care practitioner because damaged tissue prevented good visualization of the wound. (Hearing testimony of OPWDD RN)

46. From until , the Service Recipient was not seen by a health care practitioner other than RN , but phone consultations transpired between RN and the wound care practitioner on a regular basis. The Service Recipient continued to display signs of active infection. (Hearing testimony of OPWDD RN)

47. On , the Service Recipient experienced a decline in his level of consciousness and was admitted to the hospital where he was diagnosed as septic, meaning that a bacterial infection was running throughout his body and was not localized. The Service Recipient underwent surgical debridement of the left buttock wound and was treated with a course of intravenous antibiotics, which lasted approximately two weeks. He remained hospitalized during this time. (Hearing testimony of OPWDD RN)

48. The Service Recipient then returned to the facility on or about ,[6] and was prescribed oral antibiotics. The left buttock wound bed still had some yellow tissue. After a brief period "off of the oral antibiotics," the odor returned to the wound, and the Service Recipient developed an elevated temperature. (Hearing testimony of OPWDD RN)

49. On or about ,[7] the Service Recipient was again admitted to the hospital and was again treated with intravenous antibiotics. An MRI of the Service Recipient

[6] The date was not definitively established in the record.
[7] The date was not definitively established in the record.

revealed a bacterial infection of the bone underlying the debrided wound bed. While in the hospital, a peripherally inserted catheter (PIC) was inserted into the Service Recipient for post-hospital administration of intravenous antibiotics specifically used in the treatment of bacterial infection of the bone. On or about ,[8] the Service Recipient was released to a rehabilitation program for administration of the antibiotics specifically for the treatment of the bacterial bone infection. (Hearing testimony of OPWDD RN)

50. While in rehabilitation, the Service Recipient was seen at least once weekly by RN . A facility staff member was also assigned to the Service Recipient while he was in the rehabilitation center. (Hearing testimony of OPWDD RN)

51. On , while at the rehabilitation center, the Service Recipient's condition worsened and, as a result, he was admitted to the hospital with septicemia. The Service Recipient died on . (Justice Center Exhibit 34) The Service Recipient's death was, in part, attributable to his pressure wounds and the resulting septicemia. (Hearing testimony of OPWDD RN and Justice Center Exhibit 34) At the time of the Service Recipient's death, his left buttock wound was described as a "sacral decubitus ulcer" with "osteomyelitis," and was classified as Stage 4 on the Service Recipient's "ischial tuberosity." (Justice Center Exhibit 34)

52. The osteomyelitis, or bone infection, appeared to start in the area of left buttock wound that had been surgically debrided while the Service Recipient was hospitalized on . (Hearing testimony of OPWDD RN) It is also possible that the infection leading to the septicemia began in the PIC line that was installed in order to administer IV antibiotics to the Service Recipient during his stay at the rehabilitation center. (Hearing testimony of OPWDD RN) Although the wound was documented in the record as

[8] The date was not definitively established in the record.

being located on the Service Recipient's "ischium tuberosity," this same wound had persisted on the left buttock since . (Hearing testimony of OPWDD RN)

ISSUES

- Whether the Subjects have been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Neglect under SSL § 488(1) (h) is defined as:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents

> to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subjects committed the acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the acts of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that Subject [redacted]

committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject committed the acts described in Allegation 1 of the substantiated report. However, the Justice Center has not established by a preponderance of the evidence that Subject committed the acts described in Allegation 2 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject committed the acts described in Allegation 1 of the substantiated report.

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The Justice Center has established by a preponderance of the evidence that Subject committed the acts described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-68)

The investigation underlying the substantiated report was conducted by OPWDD Investigator , who testified at the hearing on behalf of the Justice Center. OPWDD RN also testified at the hearing on behalf of the Justice Center.

Each of the Subjects testified in their own behalf and provided no other evidence.

The hearing in this matter was conducted as a consolidated hearing, with eight Subjects. The substantiation letter for each Subject was virtually identical and the language used in the

substantiated allegations for each Subject was the same, with the exception of one Subject. The Subjects' contact with the Service Recipient and consequently their omissions, or commissions regarding the Service Recipient, spanned approximately from , until .

Admitted on stipulation into the hearing record was the Notice of Discipline for each of the Subjects, together with their respective labor arbitration award. (Justice Center Exhibits 43-55) The admission of these documents did not result in a finding of issue preclusions and/or collateral estoppel in this hearing, and such relief was not requested. The entirety of this decision is based upon the independent evidence presented at the hearing.

While the facts are complex, in simple terms all of the Subjects were alleged to have failed to properly administer either the dressing or the gel, as well as having failed to document the condition of the wound in the residential notes. The PONS required documentation of the condition of the wounds in the residential notes whenever the dressing was changed. Direct care staff who changed the dressing in the morning should have documented the wound condition in the residential notes. (Justice Center Exhibit 23 and Hearing testimony of OPWDD RN)

Some of the Subjects were alleged to have documented that they had performed a dressing change, when in fact they had not, and had instead relied upon the representation of other direct care staff that the dressing change had been completed.

Subject and Subject were alleged to have incorrectly transcribed into the MAR the time for administering the gel, which ultimately caused the other Subjects to incorrectly administer the gel and the dressing. Had the MAR been correctly transcribed and the dressing and the gel been administered correctly, then both treatments would have been applied simultaneously each morning at approximately 7:30 a.m.

The Subjects' counsel argued that there was no proof in the record that the Subjects failed to properly administer the Service Recipient's medication, and/or failed to accurately document administration of his medication, at least with regard to issues surrounding administration of the dressing. The basis for the Subjects' counsel's argument was that the dressing was not a medication.

The dressing was an adhesive bandage, specifically designed to promote wound healing, which was affixed to the wound area and was obtained for the Service Recipient by prescription from a medical professional. (Hearing testimony of OPWDD RN) Therefore, the Administrative Law Judge presiding over the hearing concludes that any reference to medication in the substantiation letters applies to both the gel and the dressing.

The Medication Procedure Manual (Justice Center Exhibit 21) outlines the process that the Subjects are required to follow in the administration of medicine, and specifically in the administration of the dressing and gel. With regard to the process dictated by the Medication Procedure Manual, the proof established that every medication label should be checked against the Service Recipient's MAR before administration to the Service Recipient, and this was the expectation under which the direct care staff worked. (Hearing testimony of OPWDD RN and Justice Center Exhibit 21, p. 3)

In this case, the medication labels created by the pharmacy for the dressing and the gel were not preserved. (OPWDD Investigator) The prescription for the gel was transmitted electronically from the medical provider to the pharmacy, and a copy was not kept at the facility. (OPWDD Investigator) However, an electronic printout reciting the prescription, as provided by the medical provider, was generated by the pharmacy and was provided to the facility by the pharmacy. (Justice Center Exhibit 15, second page and Hearing

testimony of OPWDD RN) The electronic prescription was reviewed by Nurse-A. (Justice Center Exhibit 15, second page) However, the only administration directions regarding the gel that were contained in the electronically generated prescription were as follows: "apply to open area of left buttock wound QD one wound." (Justice Center Exhibit 15, second page) There was no directive to apply the gel along with the dressing, and the time for administration was not prescribed.

The medical practitioner's Clinical Visit Summary of , also did not specify a time of day for administration of either the gel or the dressing, and contained essentially the same directions as the prescription: "… apply to open area of left buttock wound QDone wound", with no directive that the gel was to be administered along with the dressing. (Justice Center Exhibit 14) Additionally, the PONS created on , was not updated by Nurse-A to include the gel (although it should have been), until several days after the gel prescription was added. Had the PONS been updated properly, it would have included the directive to administer the dressing and the gel together. (Hearing testimony of OPWDD RN)

The Subjects' counsel also argued that, because the Subjects reasonably relied upon and followed the incorrect directives contained in the MAR, they did not breach their duty to the Service Recipient. The Administrative Law Judge presiding over the hearing concludes that the Subjects who followed the directives for administration of medication, meaning the dressing and gel as set forth in the MAR, did not breach their duty to the Service Recipient with regard to the timing of administration or method of administration of the gel and dressing. The nearly uncontroverted evidence in the record was that direct care staff who relied upon the MAR and

the medication labels to establish the method and time for administration of medications had met their obligations.

The Justice Center presented compelling evidence that some direct care staff members acted contrary to medical orders by removing the dressing from the Service Recipient's wounds during the overnight. (Hearing testimony of OPWDD RN) Specifically, Subject acting on the directive of the house manager removed the dressing during the overnight period. This evidence was offered in support of the allegation that these Subjects did not properly administer the Service Recipient's medication, in this instance, the dressing. The dressing was removed from the Service Recipient during the overnight on the following dates: and . (Justice Center Exhibit 37, p. 5, lines 19-22; Justice Center Exhibit 38, p. 11; Justice Center Exhibit 26; Hearing testimony of Subject ; Hearing testimony of Subject)

The dressing has the capacity to keep the wound moist and warm, an environment, which promotes wound healing. (Hearing testimony of OPWDD RN) In fact, the dressing had been effectively used to heal wounds on the Service Recipient before . (Hearing testimony of OPWDD RN)

Each time the dressing was removed from the wound, it would take approximately four hours after reapplication of the dressing for the wounds to re-establish optimal temperature and moisture level within the wounds' bed as needed for wound healing. (Hearing testimony of OPWDD RN) This is a noteworthy point, because not only did some of the Subjects remove the dressing at night, but also because of the transcription error in the Service Recipient's MAR, the dressing was removed twice within a twenty-four hour period, as opposed

to once. This resulted in an additional four-hour period each day when the wounds were not at optimal temperature and moisture level for healing.

There is a preponderance of the evidence in the record to conclude that leaving the wound uncovered during the overnight was a factor in the deterioration of the left buttock wound. Further, there is also a preponderance of the evidence in the record to conclude that because of the undiscovered error in the Service Recipient's MAR, the Service Recipient's left buttock wound went without gel for as many as twelve hours per day. The medical directive (to administer the gel and the dressing together on the left buttock wound) was not followed for at least nine days. The evidence established that during that nine-day period, the Service Recipient's left buttock wound deteriorated, and by , the left buttock wound was filled with necrotic tissue and could not be staged because visualization of the wound bed was not possible.

The left buttock wound continued to deteriorate and the Service Recipient experienced sepsis for the first time in . On , the necrotic tissue in the wound on the left buttock was surgically debrided. An infection of the bone ensued in , which was believed to have started at the site of the surgical debridement. Ultimately, even after a six-week course of IV antibiotics, the Service Recipient experienced septic shock again and died in . The Service Recipient's pressure wounds were determined to be a contributing factor in his death.

There is a preponderance of the evidence in the record to conclude that had the wounds been cared for (in particular the left buttock wound) in conformity with the medical practitioner's instructions, that the PIC line which delivered intravenous antibiotics would not have been necessary. Therefore, even if the point of entry for the bacterial infection that led to septicemia,

was the PIC line, the failure to provide proper wound care was a contributing factor in the septicemia and ultimately the death of the Service Recipient.

Subject (Adjudication Case #:)

On , Subject signed the MAR indicating that she had changed the dressing to the Service Recipient's wounds but, in fact, she did not change the dressing herself.

On , Subject changed the dressing on the Service Recipient's wounds but Subject failed to document the condition of the wounds in the residential notes, as was directed by the PONS. Additionally, Subject failed to document the condition of the wounds on this date and all other dates on which she changed the dressing, or represented in the Service Recipient's MAR that she had changed the dressing.

The Justice Center has established by a preponderance of the evidence that Subject did not properly document the status updates for the Service Recipient's pressure wounds, and failed to accurately document administration of his medication.

The Justice Center proved by a preponderance of the evidence not only that Subject Slater's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject Slater committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses'

statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Subject (Adjudication Case #:)

Subject wrote her initials in the Service Recipient's MAR indicating that she had changed the dressing on , , and . Subject failed to document the condition of the wounds in the residential notes as directed by the PONS, on any date on which she had changed the dressing, or on any date on which she represented in the MAR that she had changed the dressing.

The Justice Center has established by a preponderance of the evidence that Subject did not properly document the status updates for the Service Recipient's pressure wounds.

While there was no evidence that Subject failure to document the wounds' condition in residential notes actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect. The Justice Center proved by a preponderance of the evidence not only that Subject inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service

Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

<u>Subject</u> (Adjudication Case #:)

On , Subject signed the MAR indicating that she had changed the dressing. At the hearing, on direct examination, when asked if she had changed the dressing on , Subject testified that: "I am not remembering. … I would sign it [the Service Recipient's MAR] if I had known it was put on … well it was put on I think, it was either put on by myself or , we were in the room together that day, it was a Saturday morning … I recall that and me got him ready that day and his patch [dressing] was applied." (Hearing testimony of Subject)

Subject hearing testimony was not only waffling and inconclusive on this issue, but was also contradicted in part by statements that she had made during interrogation by the OPWDD investigator. (See Justice Center Exhibit 40, pp. 8-10) The hearing testimony of the Subject on this issue is not credited evidence.

The Justice Center has established by a preponderance of the evidence that Subject failed to properly document the status updates for the Service Recipient's pressure wounds by failing to document the condition of the wounds in the residential notes after each dressing change, and also that she failed to accurately document administration of the Service Recipient's medication by documenting in the Service Recipient's MAR that she herself had changed the dressing, when she had not actually changed the dressing.

Concerning Allegation 1 pertaining to the Subject , the Justice Center has established by a preponderance of the evidence that the Subject did not properly document the status updates for the Service Recipient's pressure wounds and did not accurately document administration of his medication.

However, with regard to Allegation 2 pertaining to the Subject , the convincing evidence established that although the Subject was designated as the Medical Liaison for the residence, she did not become aware of the dietician's recommendation for administration of the supplement until after a medical practitioner prescribed the supplement, and that the house manager had the duty to obtain the supplement, not the Subject. Consequently, the Justice Center did not establish that Subject committed neglect by failing to ensure that the Service Recipient received a treatment and dietary supplement in a timely fashion.

With regard to Allegation 1, the Justice Center proved by a preponderance of the evidence not only that Subject inaction and/or lack of attention breached her duty to

the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Subject (Adjudication Case #:)

On , Subject worked the 3:00 p.m. to 11:00 p.m. shift. During her shift, the house supervisor instructed her to remove the dressing and leave the wounds uncovered during the overnight. At about 7:30 p.m. the Subject removed the dressing for the evening and documented the condition of the wound in the residential notes. (Justice Center Exhibit 38, p. 11; Justice Center Exhibit 26 and Hearing testimony of Subject)

The Justice Center also alleged that Subject incorrectly transcribed the prescription for the dressing into the MAR on . OPWDD Investigator , who testified at the hearing on behalf of the Justice Center, concluded that the transcriber was not Subject , and that the transcriber was another facility direct care staff member. OPWDD Investigator had noted this conclusion in her investigative report. (Justice Center Exhibit 11, p. 36 and Hearing testimony of OPWDD Investigator : day one, 4 hours and 33 minute mark)

Subject testified credibly that she was not the direct care staff member who transcribed the information on that date. Subject also corroborated Subject testimony.

OPWDD RN did testify at the hearing that she believed that the Subject erroneously transcribed the prescription. However, it is determined that OPWDD RN conclusion was in error and may have arisen from the fact that the direct care staff member who did transcribe the prescription has the same initials as Subject ,

The Justice Center has established by a preponderance of the evidence that Subject failed to properly administer the Service Recipient's medication in that she removed the dressing from the Service Recipient's wounds in contravention of medical orders, and left the wounds uncovered.

The Justice Center proved by a preponderance of the evidence not only that Subject inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

<u>Subject</u> (Adjudication Case #:)

Subject worked the 7:00 a.m. to 3:00 p.m. shift on and . On both dates, Subject noted in the Service Recipient's MAR that he had changed the dressing. However, he did not change the Service Recipient's dressing. Subject also failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date on which he changed the dressing or on any date on which he represented in the Service Recipient's MAR that he had changed the dressing.

The Justice Center has established by a preponderance of the evidence that Subject Paz failed to properly document the status updates for the Service Recipient's pressure wounds when he failed to document the condition of the wounds in the residential notes after each dressing change, and also that he failed to accurately document administration of the Service Recipient's medication when he documented in the Service Recipient's MAR that he himself had changed the dressing, when he had not actually changed the dressing.

The Justice Center proved by a preponderance of the evidence not only that Subject inaction and/or lack of attention breached his duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not

elevated to a Category 1 finding shall be sealed after five years.

Subject (Adjudication Case #: 521026758)

At some point in time between , and , Subject worked with multiple facility direct care staff members to change the Service Recipient's dressing. On one of those occasions, Subject changed the dressing but another staff member signed the Service Recipient's MAR indicating that the other staff member, rather than Subject , had changed the dressing.

At some point in time between , and , Subject was instructed by the house supervisor to remove the dressing from the Service Recipient's pressure wounds. Subject did so and left the wounds uncovered for the overnight, to air out.

The Justice Center has established by a preponderance of the evidence that Subject failed to properly administer the Service Recipient's medication in that he removed the dressing from the Service Recipient's wounds, in contravention of medical orders, and left the wounds uncovered, and also that he failed to accurately document administration of the Service Recipient's medication when he allowed another facility direct care staff to document in the Service Recipient's MAR, that the direct care staff member had changed the dressing, when Subject had actually changed the dressing.

The Justice Center proved by a preponderance of the evidence not only that Subject Italia's inaction and/or lack of attention breached his duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a

preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Subject (Adjudication Case #:)

On , Subject was obligated to verify the correct transcription of the gel prescription by another facility staff member, but failed to check the Service Recipient's MAR against the Times Agreement as the procedure required her to do. As a result, the Subject did not discover the critical mistake made by the other facility staff member in specifying the time of day that the gel was to be administered to the Service Recipient. Subject either failed to discover the mistake while reviewing the Service Recipient's MAR or she failed to check the Service Recipient's MAR against the Times Agreement. At the hearing, Subject testified that "I am pretty sure that we were instructed to" deviate from the Times Agreement ". . . but I don't remember and I didn't talk to anyone. I was the one who checked so

obviously the person who transcribed it was instructed for 8 p.m." There was no other evidence in the record that anyone instructed Subject , or the other direct care staff member involved in the transcription on , to deviate from the Times Agreement. Subject did not make this assertion during the course of the investigation and made this allegation for the first time during her hearing testimony. Subject hearing testimony is not credited evidence on this issue.

Ultimately, all direct care staff relied upon this mistaken entry, and erroneously administered the gel at 8:00 p.m. instead of properly administering the gel along with the fresh dressing change at 7:30 a.m. each day.

On , at approximately 8:00 p.m., Subject was instructed by the house supervisor to leave the wounds without a dressing and uncovered. Subject applied the gel and did not reapply the dressing, leaving the wounds without a dressing during the overnight.

The Justice Center has established by a preponderance of the evidence that Subject failed to properly administer the Service Recipient's medication in that she removed the dressing from the Service Recipient's wounds in contravention of medical orders and left the wounds uncovered, and also failed to accurately document administration of his medication, when she did not discover a transcription error in the Service Recipient's MAR made on .

There is a preponderance of the evidence in the record to conclude that Subject neglect was the cause of the direct care staff's failure to apply the gel and the dressing simultaneously, ultimately leaving the buttock wound without the gel for as many as twelve hours a day for nine consecutive days. This failure contributed to the worsening of the Service

Recipient's wound, the spread of the infection to the bone and septicemia and, therefore, was a contributing factor in the death of the Service Recipient.

The Justice Center proved by a preponderance of the evidence not only that Subject inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: The request of that the substantiated report dated , be amended and sealed is

denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of Michealene Mercuri that the substantiated report dated , be amended and sealed is denied as to "Allegation 1", but is granted as to "Allegation 2." The Subject has been shown by a preponderance of the evidence to have committed neglect alleged in "Allegation 1" of the substantiation letter.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is

denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

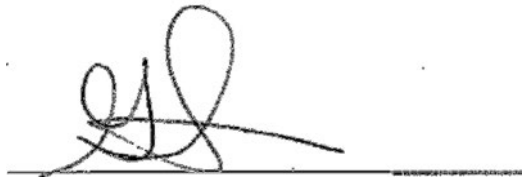
The substantiated report is properly categorized as a Category 2 act.

The request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

DATED: February 26, 2016
Syracuse, New York



Gerard D. Serlin, ALJ